Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
G. CHRISTOPHER HAMMET, MD

Respondent Name
TEXAS MUTUAL INSURANCE CO

MFDR Tracking Number
M4-14-3741-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
AUGUST 26, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Our claim has been denied based on documentation & file review does not support an emergency. We mailed a request for reconsideration with medical reports attached to show this was an emergency service."

Amount in Dispute: $15.49

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requester's billing is part of the diagnostics utilized during an outpatient admission to an emergency department. Texas Mutual denied the billing as non-emergent. The requestor documentation confirms the nonemergency."

Response Submitted by: Texas Mutual Insurance Co.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 28, 2014	CPT Code 73562-26 Knee X-ray	$15.49	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.2, effective July 1, 2012 defines a medical emergency.
3. 28 Texas Administrative Code §134.203, effective March 1, 2008, *33 Texas Register 364*, sets the reimbursement guidelines for the disputed service.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - CAC-W1-Workers compensation state fee schedule adjustment.
   - 899-Documentation and file review does not support an emergency in accordance with Rule 133.2.
   - CAC-P12-Workers' compensation jurisdictional fee schedule adjustment.

- CAC-W3, 350-In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal.
- CAC-193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 724-No additional payment after a reconsideration of services.

Issues

Were the disputed services rendered in accordance with 28 Texas Administrative Code §180.22(c)(1)? Is the requestor entitled to additional reimbursement?

Findings

According to the submitted explanation of benefits, the respondent denied reimbursement for the knee x-rays based upon "899-Documentation and file review does not support an emergency in accordance with Rule 133.2."

28 Texas Administrative Code §133.2(a)(4)(A) defines "a medical emergency is the sudden onset of a medical condition manifested by acute symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected to result in:

(i) placing the patient's health or bodily functions in serious jeopardy, or
(ii) serious dysfunction of any body organ or part."

The requestor noted in the Request for Reconsideration that "the patient came through the ER because her right leg gave out." No documentation was submitted to support these findings. As a result, the requestor has not supported position in accordance with 28 Texas Administrative Code §133.2(a)(4)(A). As a result, reimbursement is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	01/09/2015 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.